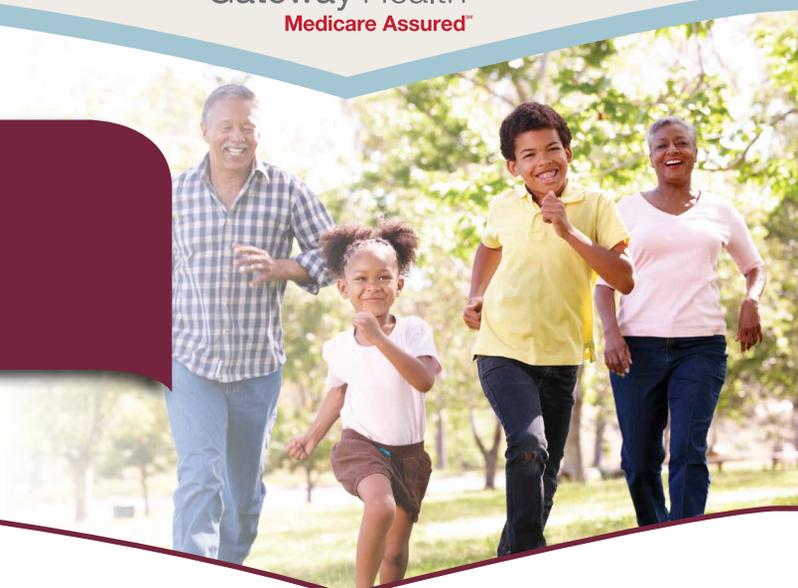


# PLAN CHOICES



## What You Need to Know

### This is a summary of drug and health services for January 1, 2017 – December 31, 2017

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limit or exclusion. To get a complete list of services we cover, please request the “*Evidence of Coverage*”.

### North Carolina Service Areas

Alexander	Davie	Madison	Swain
Alleghany	Duplin	Martin	Transylvania
Avery	Durham	McDowell	Vance
Beaufort	Greene	Mitchell	Wake
Bertie	Halifax	Northampton	Warren
Bladen	Hertford	Orange	Wayne
Caswell	Hyde	Pamlico	Wilkes
Catawba	Jackson	Pender	Yancey
Chatham	Johnston	Pitt	
Chowan	Jones	Polk	
Cumberland	Lincoln	Sampson	



## PLAN CHOICES CONTINUED...



### How to Contact Gateway

1-877-GATEWAY (428-3929)  
(TTY 711)



### How to Find a Provider or Pharmacy

[www.MedicareAssured.com](http://www.MedicareAssured.com)



### Hours of Operation

From October 1 to February 14,  
you can call us 7 days a week from  
8:00 a.m. to 8:00 p.m. Eastern time.

From February 15 to September 30,  
you can call us Monday through Friday  
from 8:00 a.m. to 8:00 p.m. Eastern time.

### More About Original Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook.

View it online at <http://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.



## Dual Eligible (D-SNP) Plans Highlights

### Medicare Assured **Diamond<sup>SM</sup>** (HMO SNP)

Monthly Plan Premium  
**\$0**

Doctor Office Visits  
**\$0** PCP

Generic Prescriptions  
as low as **\$0**

Additional Benefits  
**SilverSneakers**  
**Dental**

Preventive, Comprehensive, Dentures

**Vision**

Eye Exam and Glasses/Contacts

**Hearing**

Exam and up to \$750 for Hearing Aids

**Over-The-Counter Care**

\$110 Allowance Every 3 Months  
with Quarterly Rollover

### Medicare Assured **Ruby<sup>SM</sup>** (HMO SNP)

Monthly Plan Premium  
as low as **\$31.30\***

Doctor Office Visits  
**\$0** PCP

Generic Prescriptions  
as low as **\$0**

Additional Benefits  
**SilverSneakers**  
**Dental**

Preventive

**Vision**

Eye Exam and Glasses/Contacts

**Hearing**

Exam and up to \$750 for Hearing Aids

**Over-The-Counter Care**

\$25 Allowance Every 3 Months  
with Quarterly Rollover

# Benefits Chart

Benefit	Gateway Health Medicare Assured <b>Diamond</b> <sup>SM</sup> (HMO SNP)	Gateway Health Medicare Assured <b>Ruby</b> <sup>SM</sup> (HMO SNP)
Premium	\$0 monthly plan premium	\$31.30* monthly plan premium
Deductible	\$0 Deductible	\$0 Deductible
Maximum Out-Of-Pocket Expense	\$3,400 out-of-pocket limit for Medicare-covered services	\$6,700 out-of-pocket limit for Medicare-covered services
Hospitalization	\$0 copay per day for days 1-90	\$0 or \$275** copay per day for days 1-5; \$0 copay per day for days 6-90
Doctor Visits	\$0 PCP / \$0 Specialist copay	\$0 PCP / \$0 or \$35** Specialist copay
Preventive Care	\$0 copay	\$0 copay
Emergency Room	\$0 copay	\$0 or \$75** copay
Urgent Care	\$0 copay	\$0 or \$45** copay
Diagnostic Services/ Labs/Imaging	\$0 copay	\$0 copay
Routine Hearing (Applies to both ears combined)	\$0 copay	\$0 copay
Preventive Dental	\$0 copay for each preventive dental visit. 1 oral exam every six months and 1 cleaning every six months	\$0 copay for each preventive dental visit. 1 oral exam every six months and 1 cleaning every six months
Eyeglasses or Contact Lenses	1 pair of contact lenses per year/ 1 pair of eyeglasses (lenses and frames) per year/ \$100 maximum benefit amount every year.	1 pair of contact lenses per year/ 1 pair of eyeglasses (lenses and frames) per year/ \$100 maximum benefit amount every year.
Mental Health Services	\$0 copay	\$0 or \$35** copay
Skilled Nursing Facility	\$0 copay per day for days 1-100	\$0 copay per day for days 1-20; \$0 or \$164.50** copay per day for days 21-100
Rehabilitation Services	\$0 copay	\$0 or \$35** copay
Ambulance	\$0 copay	\$0 or \$200** copay
Transportation to Plan Approved Locations	for up to 36 one-way trips to plan-approved locations every year	for up to 24 one-way trips to plan-approved locations every year
Routine Podiatry	\$0 copay	\$0 or \$35** copay
Medical Equipment/Supplies	\$0 copay	0% or 20%** of the cost
Fitness	covered	covered
Prescriptions Initial Coverage (up to 30-day retail supply)	<b>Part D Deductible:</b> \$0  <b>Tier 1:</b> \$0.00, \$1.20 or \$3.30 copay  <b>All other Drugs:</b> \$0.00, \$3.70 or \$8.25 copay	<b>Part D Deductible:</b> \$0 or \$82*  <b>Tier 1:</b> \$0.00, \$1.20 or \$3.30 copay; or 15% of the cost  <b>All other Drugs:</b> \$0.00, \$3.70 or \$8.25 copay; or 15% of the cost

\*Could be waived based on LIS status  
 \*\*Depending on your level of Medicaid assistance



## Medicare Advantage Prescription Drug Plan (MAPD) Highlights

### Medicare Assured Prime<sup>SM</sup> (HMO MA-PD)

Monthly Plan Premium  
**\$92**

Doctor Office Visits  
**\$0** PCP

Generic Prescriptions  
as low as **\$0**

Additional Benefits  
**SilverSneakers**  
**Dental**

Preventive, Comprehensive, Dentures

**Vision**

Eye Exam and Glasses/Contacts

**Hearing**

Exam and up to \$1,000 for Hearing Aids

**Over-The-Counter Care**

\$25 Allowance Every 3 Months  
with Quarterly Rollover

### Medicare Assured Select<sup>SM</sup> (HMO MA-PD)

Monthly Plan Premium  
as low as **\$0**

Doctor Office Visits  
**\$0** PCP

Generic Prescriptions  
as low as **\$3**

Additional Benefits  
**SilverSneakers**  
**Dental**

Preventive and Dentures

**Vision**

Eye Exam and Glasses/Contacts

**Hearing**

Exam and up to \$1,000 for Hearing Aids

**Personal Emergency**

**Response System**

**Over-The-Counter Care**

\$105 Allowance Every 3 Months  
with Quarterly Rollover

# Benefits Chart

Benefit	Gateway Health Medicare Assured Prime <sup>SM</sup> (HMO MA-PD)	Gateway Health Medicare Assured Select <sup>SM</sup> (HMO MA-PD)
Premium	\$92 monthly plan premium	\$0 monthly plan premium
Deductible	\$0 Deductible	\$0 Deductible
Maximum Out-Of-Pocket Expense	\$6,700	\$6,700
Hospitalization	\$200 copay per day for days 1-5; \$0 copay per day for days 6-90	\$350 copay per day for days 1-5; \$0 copay per day for days 6-90
Doctor Visits	\$0 PCP / \$25 Specialist copay	\$0 PCP / \$40 Specialist copay
Preventive Care	\$0 copay	\$0 copay
Emergency Room	\$75 copay	\$75 copay
Urgent Care	\$25 copay	\$45 copay
Diagnostic Services/ Labs/Imaging	\$0 copay	\$0 copay
Routine Hearing (Applies to both ears combined)	\$25 copay	\$50 copay
Preventive Dental	\$0 copay for each preventive dental visit. 1 oral exam every six months and 1 cleaning every six months	\$0 copay for each preventive dental visit. 1 oral exam every six months and 1 cleaning every six months
Eyeglasses or Contact Lenses	1 pair of contact lenses per year/ 1 pair of eyeglasses (lenses and frames) per year/ \$150 maximum benefit amount every year.	1 pair of contact lenses per year/ 1 pair of eyeglasses (lenses and frames) per year/ \$225 maximum benefit amount every year.
Mental Health Services	\$25 copay	\$40 copay
Skilled Nursing Facility	\$0 copay per day for days 1-20; \$164.50 copay per day for days 21-100	\$0 copay per day for days 1-20; \$164.50 copay per day for days 21-100
Rehabilitation Services	\$25 copay	\$40 copay
Ambulance	\$150 copay	\$200 copay
Transportation to Plan Approved Locations	not covered	not covered
Routine Podiatry	\$25 copay	\$50 copay
Medical Equipment/Supplies	20% of the cost	15% of the cost
Fitness	covered	covered
Prescriptions Initial Coverage (up to 30-day retail or mail-order supply)	<b>Part D Deductible:</b> \$250 <b>Tier 1:</b> \$0.00 copay <b>Tier 2:</b> \$20.00 copay <b>Tier 3:</b> \$45.00 copay <b>Tier 4:</b> \$95.00 copay <b>Tier 5:</b> 28% of the cost	<b>Part D Deductible:</b> \$200 <b>Tier 1:</b> \$3.00 copay <b>Tier 2:</b> \$16.00 copay <b>Tier 3:</b> \$45.00 copay <b>Tier 4:</b> \$95.00 copay <b>Tier 5:</b> 29% of the cost

Gateway Health<sup>SM</sup> offers HMO plans with a Medicare Contract. Some Gateway Health plans have a contract with Medicaid in the states where they are offered. Enrollment in these plans depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium – The State pays the Part B premium for full dual members.

Premium, co-pays, co-insurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

Gateway Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.